21st Century Insurance Company
PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: _____ **Loss Number:** _____
Patient's Name: _____
Medical Provider's Name: Non Surgical Orthopedics of New Jersey, PC

I authorize and request 21st Century Insurance (21st) to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date: _____
Patient's Signature or Parent/Legal Guardian

I have read the information contained in 21st's informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively, "**Plan**") and, as a condition precedent to 21st's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) have complied and will comply with all the requirements of the **Plan**.
2) I (We) will initiate all pre-certification review and decision point review requests as required by the **Plan**.
3) I (We) will submit disputes as defined in the **Plan** to the Internal Dispute Resolution Process set forth therein, including First Level and Second Level Appeals. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C.11:3-5.
4) I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
6) In the event that I (we) fail to comply with paragraphs one (1) though five (5) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (we) agree that this assignment is the only valid assignment of benefits. I (we) agree that this assignment of benefits may require 21st's written consent. I (we) agree that 21st has the right to reject, terminate or revoke this assignment of benefits.

_____ Date: _____
Provider's Signature
_____ TIN Number: 45-2741386

Provider's Name (Please Print)
Address: Non Surgical Orthopedics of New Jersey, PC
400 Route 34, Suite A
Matawan, NJ 07747